Contract Number:

Comment [RL1]: This draft is a red-line strikeout of the 2010 Final Contract with all 2011 changes incorporated.

This Agreement has been entered into between
HEALTH PLAN
(Hereinafter referred to as "CONTRACTOR")
and the
WASHINGTON STATE HEALTH CARE AUTHORITY
(Hereinafter referred to as "HCA")
For the Washington Basic Health Plan

In consideration of the payment of monthly fees to be made by HCA and the conditions specified in this Agreement, CONTRACTOR agrees to provide services and benefits, as herein specified, for enrollees in the Washington Basic Health Plan (BH), consistent with chapter 70.47 Revised Code of Washington (RCW) and chapter 182-25 Washington Administrative Code (WAC) as amended. This Agreement is subject to all of the terms and conditions set forth herein, including the Exhibits attached hereto and included in this Agreement by this reference.

This Agreement is effective January 1, ~~2010~~2011, at 12:01 A.M., Pacific Standard Time, at Olympia, Washington, and will remain in effect through December 31, ~~2010~~2011, unless terminated earlier or renewed. HCA reserves the right to negotiate annual renewals of this Agreement.

In Witness Whereof, CONTRACTOR and HCA have caused this Agreement to be signed by their respective officers who are duly authorized as of the effective date.

Carrier Name	HEALTH CARE AUTHORITY
By: _____	By: _____
Title: _____	Title: Deputy Administrator
Date: _____	Date: _____
Address for Notice Purposes:	Address for Notice Purposes: Basic Health Procurement Manager P O Box 42685 Olympia, Washington 98504-2685

This Contract is approved as to form by the Office of the Attorney General.

TABLE OF CONTENTS

Exhibits

1. DEFINITIONS

For purposes of this Agreement, including all exhibits and amendments, the following terms shall have the meanings indicated:

1.1. Administrator

"Administrator" means the Administrator of the Health Care Authority (HCA). The Administrator may designate a representative to act on ~~his~~ the Administrator's behalf. Any designation may include the representative's authority to hear and determine any matter.

1.2. Anniversary Date

"Anniversary Date" means the first day of January.

1.3. Basic Health Plus (BH Plus)

"Basic Health Plus" means the federal aid medical care program jointly administered by HCA and Washington State Department of Social and Health Services (DSHS) for children under age 19 who qualify for Medical Assistance as defined under Title XIX of the federal social security act.

1.4. Certificate of Coverage (COC) or Member Handbook

"Certificate of Coverage" or "COC" means the Member Handbook, Exhibit 2 of this Agreement, published by HCA, which describes requirements for eligibility and enrollment, Covered Services, and other terms and conditions that apply to Enrollee participation.

1.5. Consumer Assessment of Health Plans Survey (CAHPS™)

"Consumer Assessment of Health Plans Survey (CAHPS™)" means a commercial and Medicaid standardized survey instrument used to measure client experience of health care.

~~1.5.~~1.6. CONTRACTOR

"CONTRACTOR" means the entity contracting with HCA to provide a prepaid, comprehensive system of medical and health care delivery, including preventive, primary, specialty, and ancillary health services set forth in the COC (Exhibit 2).

~~1.6.~~1.7. Coordination of Benefits (COB)

"Coordination of Benefits" or "COB" means the rules for administering HCA health contracts, whose hospital, medical, or surgical benefits may be reduced because of other existing coverages.

~~1.7.~~1.8. **Covered Services**

"Covered Services" means services set forth in the COC (Exhibit 2).

~~1.8.~~1.9. **Dependent**

"Dependent" means family members defined as eligible for Basic Health Covered Services in the COC (Exhibit 2).

~~1.9.~~1.10. **Enrollee**

"Enrollee" means an individual eligible for Covered Services according to the eligibility and enrollment criteria set forth in the COC (Exhibit 2) and whom HCA has accepted for coverage.

~~1.10.~~1.11. **External Quality Review (ER**

"External Quality Review (EQR)" means the analysis and evaluation by an EQRO, of aggregated information on quality, timeliness, and access to health care services that a managed care organization or their contracted providers furnish to Medicaid recipients.

1.12. External Quality Review Organization (EQRO)

"External Quality Review Organization (EQRO)" means an organization that meets the competence and independence requirements set forth in 42 CFR 438.354, and performs external quality review, other EQR-related activities as set forth in 42 CFR 438.358 or both.

1.13. Health Employer Data and Information Set (HEDIS®)

"Health Employer Data and Information Set (HEDIS®)" is a set of performance measures used in the managed care industry. HEDIS® is developed and maintained by the National Committee for Quality Assurance (NCQA), a not-for-profit organization committed to assessing, reporting on, and improving the quality of care provided by organized delivery systems.

~~1.11.~~1.14. **HIPAA**

"HIPAA" means the Health Insurance Portability and Accountability Act of 1996 (as codified at 42 USC 1320(d) et seq).

1.15. Managed Care Organization (MCO)

"Managed Care Organization" means a health carrier that contracts with the state of Washington to provide managed health care services.

~~1.12.~~1.16. **Material Provider**

"Material Provider" means a Participating Provider whose loss would degrade access to care in the Service Area. In evaluating whether a degradation of access has occurred, HCA will consider the effect on appointment wait times, accessibility of services, continuity of care, and the accessibility of Providers in relation to the ~~Quality Improvement Standards set forth in Exhibit 4 and the~~ Network Accessibility Guidelines set forth in Exhibit ~~7~~6.

~~1.13.~~1.17. **Maternity Benefits Program**

"Maternity Benefits Program" means the federal aid medical care program (also known as BH S-Medical Program) jointly administered by the HCA and Department of Social and Health Services for pregnant women who qualify for Medical Assistance as defined under Title XIX of the federal social security act.

~~1.14.~~1.18. **Medical Assistance**

"Medical Assistance" means the federal aid medical care program provided to categorically needy persons as defined under Title XIX of the federal social security act.

~~1.15.~~1.19. **Medicare**

"Medicare" means the programs of medical care coverage set forth in Title XVIII of the federal social security act as amended by Public Law 89-97 or as hereafter amended.

1.20. Partial HEDIS® Compliance Audit TM Standards, Policies, and Procedures

"Partial HEDIS® Compliance Audit ™ Standards, Policies and Procedures" means the methods used to validate the accuracy and reliability of HEDIS® data by conducting a thorough assessment of MCO information systems, coupled with an assessment of compliance with production of HEDIS® performance measures. The compliance audit includes an audit of the survey sample for the CAHPS™ survey.

~~1.16.~~1.21. **Participating Provider**

"Participating Provider" means a person, practitioner ~~(as defined in the Quality Improvement Standards, Exhibit 4)~~, or entity having a written agreement with CONTRACTOR or employed by the CONTRACTOR to provide health care services to Enrollees during the term of this Agreement.

~~1.17.~~1.22. **Personal Information**

"Personal Information" means information identifiable to any person, including, but not limited to, information that relates to a person's name, health, finances, education, business, use or receipt of governmental services or other activities, addresses, telephone numbers, social security numbers, driver

license numbers, other identifying numbers, and any financial identifiers that may be exempt from disclosure to the public or other unauthorized persons under chapter 42.56 RCW or other applicable state and federal statutes.

~~1.18.~~1.23. **Primary Care Physician (PCP)**

"Primary Care Physician" or "PCP" means a Participating Provider who has the responsibility for supervising, coordinating, and providing primary health care to Enrollees, initiating referrals for specialist care, and maintaining the continuity of Enrollee care. PCPs may include, but are not limited to, Pediatricians, Family Practitioners, General Practitioners, Internists, Physician Assistants (under the supervision of a physician), or Advanced Registered Nurse Practitioners (ARNP), as designated by CONTRACTOR.

~~1.19.~~1.24. **Privacy Rule**

"Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 CFR Parts 160 and 164, Subparts A and E.

~~1.20.~~1.25. **Provider**

"Provider" means an individual medical professional, hospital, skilled nursing facility, other facility or organization, pharmacy, program, equipment and supply vendor, or other entity that provides care or bills for health care services or products.

~~1.21.~~1.26. **Referral Provider**

"Referral Provider" means a provider, who is not the Enrollee's PCP, to whom an Enrollee is referred for Covered Services.

~~1.22.~~1.27. **Service Area**

"Service Area" means the geographic area covered by this Agreement set forth in Exhibit ~~6~~5.

~~1.23.~~1.28. **Subcontract**

"Subcontract" means a written agreement between CONTRACTOR and a Subcontractor, or between a Subcontractor and another Subcontractor, to perform all or a portion of the duties and obligations CONTRACTOR is obligated to perform under the terms of this Agreement.

~~1.24.~~1.29. **Subscriber**

"Subscriber" means that person or those persons defined in the COC (Exhibit 2) as the person on a BH account who is responsible for payment of premiums and copayments and to whom BH sends all notices and communications.

1.24. Consumer Assessment of Health Plans Survey (CAHPS)

"Consumer Assessment of Health Plans Survey (CAHPS)" means a commercial and Medicaid standardized survey instrument used to measure client experience of health care.

1.25. External Quality Review (EQR)

"External Quality Review (EQR)" means the analysis and evaluation by an EQRO, of aggregated information on quality, timeliness, and access to health care services that a managed care organization or their contracted providers furnish to Medicaid recipients.

1.26. External Quality Review Organization (EQRO)

"External Quality Review Organization (EQRO)" means an organization that meets the competence and independence requirements set forth in 42 CFR 438.354, and performs external quality review, other EQR-related activities as set forth in 42 CFR 438.358 or both.

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"Partial HEDIS® Compliance Audit™ Standards, Policies and Procedures" means the methods used to validate the accuracy and reliability of HEDIS® data by conducting a thorough assessment of MCO information systems, coupled with an assessment of compliance with production of HEDIS® performance measures. The compliance audit includes an audit of the survey sample for the CAHPS survey.

1.28. Health Employer Data and Information Set (HEDIS®)

"Health Employer Data and Information Set (HEDIS®)" is a set of performance measures used in the managed care industry. HEDIS® is developed and maintained by the National Committee for Quality Assurance (NCQA), a not-for-profit organization committed to assessing, reporting on, and improving the quality of care provided by organized delivery systems.

1.29. Managed Care Organization (MCO)

"Managed Care Organization" means a health carrier that contracts with the state of Washington to provide managed health care services.

2. ELIGIBILITY AND ENROLLMENT

2.1. Eligibility

Eligibility of Subscribers and their Dependents and the terms of their coverage shall be as set forth in the COC (Exhibit 2), subject to amendment in accordance with current and future provisions of chapter 70.47 RCW and Title 182 WAC.

2.2. Enrollment

Each applicant for enrollment must file an application form with HCA and must fulfill all conditions of enrollment described in the COC (Exhibit 2). Coverage begins for Enrollees as described in the COC (Exhibit 2).

At the direction of HCA, CONTRACTOR shall enroll any person for whom HCA pays monthly fees on a retroactive basis for Covered Services, even though the person may not have complied with the prescribed time limits for obtaining coverage. When a person has been retroactively enrolled, services covered during that retroactive period may be limited to those provided by Participating Providers, or emergency care services. In addition, with regard to services that require preauthorization, retroactive coverage may be limited to services that would have been preauthorized had the Enrollee been actively enrolled at the time services were provided.

2.3. Limited Enrollment

Upon at least 90 calendar days' prior written notice, and with prior agreement in writing by HCA, CONTRACTOR may limit enrollment or set priorities for acceptance of new applications for enrollment. Said limitations shall be based on a determination by CONTRACTOR that its capacity, in relation to its total enrollment, is not adequate to provide services to additional persons. The consent of HCA will not be unreasonably withheld. HCA may also limit enrollment upon at least 90 calendar days' written notice to CONTRACTOR.

2.4. Identification Cards and CONTRACTOR Information

HCA shall:

2.4.1. Publish and make available upon request the COC to all persons enrolled in BH as of January 31 of each calendar year.

2.4.2. Issue a notice to all new Enrollees and Enrollees requesting a change of BH CONTRACTORS, providing the following information: (1) the name(s) or other identification of the Enrollee(s) eligible for coverage; (2) the effective date of coverage for each Enrollee; and (3) the BH CONTRACTOR selected by the Enrollee(s). This notice will serve as temporary membership identification pending issuance of identification cards by CONTRACTOR. An Enrollee's out-of-pocket maximum liability begins on the effective date of coverage with CONTRACTOR.

CONTRACTOR shall:

2.4.3. Respond promptly and courteously to inquiries from Enrollees and candidates for enrollment in BH coverage. CONTRACTOR shall provide sufficient, accurate oral and written information to assist Enrollee to make informed decisions about enrollment. CONTRACTOR shall provide Enrollees

with a summary of benefits, including an Enrollee's rights and obligations related to the administration of deductibles, coinsurance, and out-of-pocket maximums. CONTRACTOR shall ensure Enrollees have written information about how to obtain care in CONTRACTOR'S health care system and network and the role of the PCP in providing and authorizing care. Upon request from Enrollee, CONTRACTOR shall provide adequate and timely information to Enrollees or potential Enrollees so that they are informed as to how they can access care and choose an appropriate PCP for coverage prior to their effective date of enrollment with the CONTRACTOR.

2.4.4. Submit any materials intended primarily for use by BH Enrollees or candidates for enrollment in BH coverage for approval by HCA prior to distribution. In addition, CONTRACTOR must submit to BH a courtesy copy of all other materials sent to BH Enrollees or candidates for enrollment in BH coverage.

2.4.5. Distribute the CONTRACTOR'S COC to Enrollees enrolled for coverage effective on or after February 1 within 15 business days of receipt of confirmation of enrollment from HCA. CONTRACTOR may distribute the COC electronically, following written notice to Enrollees. The written notice must offer Enrollees the option of a hard copy version of the COC free of charge and must also include a self-addressed postcard or envelope along with instructions for obtaining a hard copy of the COC from the CONCTRACTOR, either by phone request or by mail. If the Enrollee chooses to ~~mail the request for~~receive the COC by mail, CONTRACTOR must send the Enrollee a hard copy of the COC within 15 business days of receipt of the written notice.

2.4.6. Distribute to Enrollees, upon request, a copy of CONTRACTOR'S drug formulary or list used for Enrollees covered under the terms of this Agreement. CONTRACTOR shall ensure Enrollees know how to request a copy of the formulary and that they have timely access to the formulary upon request.

2.4.7. Distribute to Enrollees in writing, at the time of enrollment, or at any time upon request, information about the CONTRACTOR'S complaint and appeal procedures.

2.4.8. Assist HCA in the distribution of any disclosure forms, benefits descriptions or other material that may be required by HCA, or by any provision of Washington or federal law or by regulation.

2.4.9. Send identification cards to Enrollees. This information must be sent to the Enrollees within 15 business days of receipt of enrollment verification from HCA.

2.4.10. Ensure that Participating Providers accept the HCA-issued notice detailed at Section 2.4.2. of this Agreement as verification of enrollment until an official identification card is issued to the Enrollee by CONTRACTOR.

2.4.11. Provide all Participating Providers with timely information so that adequate care for Enrollees can be reasonably assured. Timely information includes, but is not limited to, enrollment information and, where appropriate, preauthorizations for Covered Services or referrals to Participating and non-Participating Providers. Enrollment data must be available to Participating Providers within 5 business days after receipt from HCA.

2.4.12. Issue Explanation of Benefits (EOB) reflecting patient's responsibility for claims and accumulated amount toward deductibles and out-of-pocket maximums. CONTRACTOR'S appropriate staff must have electronic access to an Enrollee's benefit history in order to provide timely response to Enrollee queries related to benefit usage.

2.5. Medical Assistance Recipients

Pursuant to RCW 70.47.110, DSHS will determine if a BH Plus or Maternity Benefits Program applicant is eligible for Medical Assistance under chapter 74.09 RCW. DSHS will make payments to HCA on behalf of any BH Plus or Maternity Benefits Program Enrollee. Any Enrollee on whose behalf HCA makes such payments to CONTRACTOR, will be entitled to the BH Plus or the Maternity Benefits Program services set forth in the BH Plus and Maternity Benefits Program Agreement signed by CONTRACTOR and HCA, effective January 1, ~~2010~~2011. CONTRACTOR agrees to cooperate with HCA in effecting the smooth transfer of Enrollees from BH to BH Plus or the Maternity Benefits Program. CONTRACTOR is required to cooperate with DSHS to ensure compliance with the BH Plus and Maternity Benefits Program contract terms.

2.6. Service Area

2.6.1. CONTRACTOR'S Service Area includes those counties and partial counties set forth in Exhibit ~~6~~5. Enrollees are eligible to enroll with CONTRACTOR if they reside in CONTRACTOR'S Service Area. If the U.S. Postal Service alters the ZIP codes within CONTRACTOR'S Service Area, HCA shall redetermine the boundaries of the Service Area.

2.6.2. HCA may require CONTRACTOR to cover full ZIP codes that cross county borders served by CONTRACTOR in order to assure continuity of care or ready access to health care services. Enrollees may be required by CONTRACTOR to access care in the county where CONTRACTOR has been awarded a contract even though the Enrollee's residence may be in the portion of the ZIP code which crosses the county line.

2.6.3. CONTRACTOR shall not change its Service Area without prior approval of the HCA. CONTRACTORS must have a sufficient number of Participating Providers in a Service Area before requesting a Service Area expansion. HCA shall apply the Network Accessibility Guidelines (Exhibit ~~6~~7) when evaluating the adequacy of the network.

2.6.4. HCA reserves the right to request full reimbursement for any costs incurred by HCA as a result of a CONTRACTOR'S withdrawal from a Service Area. HCA may reduce CONTRACTOR'S ~~final December premium or final mid-year premium, whichever occurs earliest,~~premiums to recover those costs. This reimbursable expense will be in addition to any other provision of this Agreement.

3. TERMINATION AND RELATED PROVISIONS

3.1. Reservation of Rights and Remedies

A material default or breach in this Agreement will cause irreparable injury to HCA. In the event of any claim for default or breach of this Agreement, no provision in this Agreement shall be construed, expressly or by implication, as a waiver by the state of Washington to any existing or future right or remedy available by law. Failure of the state of Washington to insist upon the strict performance of any term or condition of this Agreement or to exercise or delay the exercise of any right or remedy provided in this Agreement or by law, or the acceptance of (or payment for) materials, equipment or services, shall not release CONTRACTOR from any responsibilities or obligations imposed by this Agreement or by law, and shall not be deemed a waiver of any right of the state of Washington to insist upon the strict performance of this Agreement. In addition to any other remedies that may be available for default or breach of this Agreement, in equity or otherwise, HCA may seek injunctive relief against any threatened or actual breach of this Agreement without the necessity of proving actual damages. HCA reserves the right to recover any or all administrative costs incurred in the performance of this Agreement during or as a result of any threatened or actual breach.

3.2. Termination By HCA

HCA may terminate this Agreement upon occurrence of any of the following:

3.2.1. Any threatened or actual material breach by CONTRACTOR. Upon HCA's knowledge of a material breach by CONTRACTOR, HCA shall provide an opportunity for CONTRACTOR to cure the breach or end the violation. HCA reserves the right to terminate this Agreement if CONTRACTOR does not cure the breach or end the violation within the time specified by HCA, or immediately terminate this Agreement if CONTRACTOR has breached a material term of this Agreement and cure is not possible.

3.2.2. HCA has reasonably determined that management practices adopted by CONTRACTOR or the current financial condition of CONTRACTOR present a substantial material risk of interrupting or interfering with the delivery of Covered Services or the quality of such services.

3.2.3. Receipt of notice of change in ownership or other material change in organization pursuant to Section 12.24. of this Agreement, "Notification of Organizational Changes," if HCA reasonably determines that such change presents a risk of interrupting or interfering with the delivery or quality of Covered Services.

3.2.4. HCA has informed CONTRACTOR in writing of its continuing failure to arrange for the provision of Covered Services or of other continuing unsatisfactory performance by CONTRACTOR and CONTRACTOR has not taken reasonable, effective, and prompt steps to correct the alleged failures or unsatisfactory performance or to demonstrate that the concerns of HCA are not justified.

3.2.5. Any anniversary date of this Agreement.

3.2.6. Any violation of the State Ethics Law, chapter 42.52 RCW

3.2.7 The HCA has reasonably determined that CONTRACTOR's provider network does not comply with the Network Accessibility Guidelines set forth in Exhibit 6 and presents a substantial material risk of interrupting or interfering with the delivery of Covered Services or the quality of such services. Provided

however, HCA shall consult with CONTRACTOR in good faith during a 90-day notice period and cooperate with CONTRACTOR to seek to arrive at an accommodation that meets the State of Washington's need without termination. Should CONTRACTOR fail to satisfy the State of Washington's needs within such period, this Agreement shall terminate upon HCA"s written notice to CONTRACTOR..

3.3. Termination By CONTRACTOR

If HCA fails to pay the monthly fees in the amounts and manner specified in Section 4 (Monthly Fees) of this Agreement, CONTRACTOR may terminate this Agreement by giving advance written notice received by HCA of not less than 60 calendar days prior to termination.

3.4. Termination Procedure

3.4.1. Except as provided in Section 3.2.7. of this Agreement, a~~A~~ party seeking to terminate this Agreement pursuant to Sections 3.2. or 3.3. of this Agreement shall give not less than 60 calendar days' advance written notice to the other party of the intent to terminate. The notice shall explain the reason for termination and shall include an explanation of any alleged breach. Notwithstanding anything herein provided to the contrary, the breaching party shall have the right to cure the breach during the 60-calendar day notice period. The party seeking to terminate this Agreement shall review any efforts to cure the alleged breach and determine whether such efforts are sufficient to cure the breach. Failure of a party to cure the breach within the 60 calendar day time period shall allow the other party to terminate this Agreement upon the delivery of a written notice declaring a termination.

3.4.2. Termination shall be in addition to any other remedies that may be available by law or under this Agreement. Termination of this Agreement will not terminate the rights or liabilities of either party arising out of performance for any period prior to such termination.

3.5. Termination for Withdrawal or Reduction of Funding

In the event funding from any state, federal, or other sources is withdrawn, substantially reduced, or limited in any way after the ~~effective date of this Agreement~~date this Agreement is signed and prior to the termination date, HCA may terminate this Agreement upon 60 calendar days' prior written notice to CONTRACTOR or upon the effective date of withdrawn or reduced funding, whichever occurs earlier. If this Agreement is so terminated, HCA shall be liable only for payment in accordance with the terms of this Agreement for services rendered prior to the effective date of termination.

3.6. Termination of Enrollee Coverage

3.6.1. Enrollee coverage may be terminated by HCA in accordance with the eligibility provisions set forth in WAC 182-25-030 and as described in the COC (Exhibit 2).

3.6.2. In the event that an Enrollee appeals a disenrollment decision through the HCA appeals process, HCA may require CONTRACTOR to continue to

provide services to the Enrollee under the terms of this Agreement pending the final decision. CONTRACTOR agrees to continue to provide services, provided HCA continues to pay the monthly fee to CONTRACTOR for such Enrollee according to the terms of this Agreement. With prior approval of HCA, CONTRACTOR may discontinue providing services to an Enrollee during the appeals process if the Enrollee has demonstrated a danger or threat to the safety or property of the CONTRACTOR, its staff, Providers, patients, or visitors.

3.6.3. CONTRACTOR may request that HCA ~~immediately~~ terminate an Enrollee's coverage for repeated ~~failure to pay copayments, coinsurance or other cost sharing in full on a timely basis~~; abuse, intentional misconduct, danger or threat to the safety of the CONTRACTOR, its staff, Providers, patients, or visitors~~; or refusal to accept or follow procedures or treatment determined by CONTRACTOR to be essential to the health of the Enrollee, when CONTRACTOR has advised the Enrollee and demonstrated to the satisfaction of BH that no professionally acceptable alternative form of treatment is available from CONTRACTOR~~.

Prior to requesting disenrollment for abuse, intentional misconduct, or posing an imminent danger or threat, CONTRACTOR shall ~~ensure~~ validate CONTRACTOR'S Medical Director has reviewed the circumstances to ensure the Enrollee has been appropriately evaluated and offered all appropriate Covered Services.

Prior to requesting disenrollment under the terms of this Section, CONTRACTOR must: (a) afford the Enrollee with notice of the action CONTRACTOR intends to take; and (b) ensure the Enrollee is afforded an opportunity to be heard~~; and (c) in the case of non-payment, the Enrollee is given an opportunity to make payments prior to the disenrollment request~~. Involuntary termination of an Enrollee under this Section will be considered a "Special Circumstance" and HCA shall approve or disapprove CONTRACTOR'S request for termination as soon as reasonably possible but no later than 30 business days after receipt of such request and CONTRACTOR'S supporting documentation.

3.6.4. If an Enrollee is confined in a hospital or skilled nursing facility for which benefits are provided when Basic Health coverage ends and the Enrollee is not immediately covered by other health care coverage, benefits will be extended until the earliest of the following events: (1) the Enrollee is discharged from the hospital or from a hospital to which the Enrollee is directly transferred; (2) the Enrollee is discharged from a skilled nursing facility when directly transferred from a hospital when the skilled nursing facility confinement is in lieu of hospitalization; (3) the Enrollee is discharged from the skilled nursing facility or from a skilled nursing facility to which the Enrollee is directly transferred; (4) the Enrollee is covered by another health plan which will provide benefits for the services; or (5) benefits are exhausted.

4. MONTHLY FEES

4.1. Remittance

Subject to the provisions of Section 12.18. of this Agreement (Intermediate Sanctions), HCA shall remit a monthly fee to CONTRACTOR on behalf of each Enrollee in full consideration of the work to be performed by CONTRACTOR under this Agreement. The "Monthly Fee" specified in Exhibit 1, shall be based on HCA's then current enrollment information. Payment shall be remitted to CONTRACTOR on or before the 15th day of the month during which Covered Services are to be provided to eligible Enrollees. Monthly fees for BH Plus and the Maternity Benefits Program are set forth in the separate Agreement between HCA and CONTRACTOR.

4.2. Retroactive Payment or Refund

Retroactive payment or refund of monthly fees to reflect additions or deletions of Enrollees added or omitted based on HCA's enrollment records will be made by HCA.

4.3. Responsibility for Enrollment Data

4.3.1. HCA will furnish current enrollment information to CONTRACTOR upon which CONTRACTOR may rely without further verification. HCA may provide enrollment verification by telephone, which will be followed by written or electronic confirmation.

4.4. Renegotiation of Rates

The Monthly Fees set forth in Exhibit 1 shall be subject to negotiation during the Agreement period if HCA determines that changes in federal or state law or regulations materially affect the risk to CONTRACTOR or its costs of doing business.

5. SERVICES, BENEFITS, EXCLUSIONS, AND LIMITATIONS

5.1. Plan Description

The services, benefits, exclusions, and limitations applicable to Enrollees are set forth in the COC (Exhibit 2).

5.2. Self-Referral for Women's Health Care

5.2.1. Pursuant to WAC 284-43-250, access to women's health care Providers may not be restricted based solely on a woman's choice of PCP. If CONTRACTOR restricts access for other services to a subnetwork of fewer than the entire panel of Participating Providers available to all Enrollees, access to women's health care services may not be restricted to the same subnetwork, but Enrollees may be required to use a Participating Provider.

5.2.2. If an Enrollee is required to use facilities (such as hospitals) affiliated with her PCP or the PCP's subnetwork for services generally, this limitation may not be imposed for women's health care services. Enrollees may be required to use a Participating Provider facility within CONTRACTOR'S network.

5.3. Preventive Care

5.3.1. Primary and secondary preventive care services shall be provided in accordance with the edition of the "Guide to Clinical Preventive Services" of the U.S. Preventive Services Task Force as of the effective date of this Agreement and as follows:

5.3.1.1. Those services rated "A" shall be covered and CONTRACTOR shall take active steps to assure their provision.

5.3.1.2. Those services rated "B" shall be covered.

5.3.1.3. Those services rated "D" shall not be covered.

5.3.1.4. Those services rated "I" shall not be covered, and CONTRACTOR shall take steps to determine that if those services are provided, there is informed consent.

5.3.1.5. Those services rated "C" and those services not rated shall be provided at the discretion of CONTRACTOR to determine the appropriate level of care for the Enrollee consistent with the terms of the COC (Exhibit 2) and this Agreement.

5.3.2. CONTRACTOR may substitute generally recognized accepted guidelines~~, such as those developed by the American Academy of Pediatrics or the Canadian Task Force on the Periodic Health Examination, as a basis to define the content and periodicity of coverage of preventive services~~, as long as such substitution is approved in advance, in writing, by HCA.

5.3.3. CONTRACTOR shall provide the Enrollee with a description of preventive care benefits to be used by CONTRACTOR in the materials required by Section 2.4. ~~(Identification Cards and CONTRACTOR Information).~~

6. COORDINATION OF BENEFITS (COB)

6.1. Benefits Subject To This Provision

Benefits under this Agreement shall be coordinated as prescribed in this Section.

6.2. "Plan" Defined

6.2.1. "Plan," as used in this Section 6. only, ~~means~~ includes any of the following sources of benefits or services:

6.2.1.1. Group or blanket disability insurance policies and health care service contractor and health maintenance organization group agreements, issued by insurers, health care service contractors, and health maintenance organizations, respectively;

6.2.1.2. Labor-management trustee Plans, labor organization Plans, employer organization Plans or employee benefit organization Plans;

6.2.1.3. Governmental programs; and

6.2.1.4. Coverage required or provided by any statute.

6.2.2. "Plan" shall be construed separately with respect to each health contract or other arrangement for benefits or services, and separately with respect to the respective portions of any such health contract or other arrangement which do and which do not reserve the right to take the benefits or services of other health contracts or other arrangements into consideration in determining its benefits.

6.3. "Allowable Expense" Defined

6.3.1. "Allowable Expense," as used in this Section 6., means the customary and reasonable charge for any necessary health care service or supply when the service or supply is covered at least in part under any of the Plans involved. When a Plan provides benefits in the form of services or supplies rather than cash payments, the reasonable cash value of each service rendered or supply provided shall be considered an allowable expense. The difference between the cost of a private hospital room and the cost of a semi-private hospital room is not considered an allowable expense unless the Enrollee's stay in a private hospital room is considered medically necessary under at least one of the Plans involved.

6.3.2. In the case where coverage is provided through internal maximums in the contract, CONTRACTOR shall coordinate benefits in such a manner as to allow coverage for the internal maximums provided for in both the primary contract and this Agreement. If internal maximums are provided for by a specified maximum dollar amount, then CONTRACTOR must coordinate benefits as secondary Plan until benefits under the primary contract are exhausted, then pay BH benefits (up to BH internal maximum dollar amount) until BH benefits are exhausted. If internal maximums are provided for by a specified maximum number of visits, then CONTRACTOR must coordinate benefits as secondary Plan until benefits under the primary contract are exhausted, then pay BH benefits (up to BH maximum) until BH benefits are exhausted.

6.4. "Claim Determination Period" Defined

"Claim Determination Period," as used in this Section 6., means a calendar year.

6.5. Facility of Payment

Whenever payments which should have been made under this Agreement in accordance with this provision have been made under any other Plan, CONTRACTOR shall have the right, exercisable alone and in its sole discretion, to pay over to any Plan making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of this provision. Amounts so paid shall be considered benefits paid under this Agreement and, to the extent of such payments, CONTRACTOR shall be fully discharged from liability under this Agreement. This provision shall not apply to the extent it conflicts with the requirements of RCW 48.44.026.

6.6. Right of Recovery

Whenever payments have been made by CONTRACTOR with respect to allowable expenses in excess of the maximum amount of payment necessary to satisfy the intent of this Agreement, CONTRACTOR shall have the right to recover such payments, to the extent of such excess, from one or more of the following, as CONTRACTOR shall determine: (1) any persons to or for or with respect to whom such payments were made, (2) any other insurers, (3) any service Plans, or (4) any other organizations or other Plans.

6.7. Effect on Benefits

6.7.1. This Section shall apply in determining the benefits for a person covered under this Agreement for a particular claim determination period if, for the allowable expenses incurred as to such person during such period, the sum of: (1) the benefits that would be payable under this Agreement in the absence of this provision, and (2) the benefits that would be payable under all other health Plans in the absence therein of provisions of similar purpose to this provision would exceed such allowable expenses.

6.7.2. As to any claim determination period with respect to which this Section is applicable, the benefits that would be payable under this Agreement in the absence of this provision for the allowable expenses incurred as to such person during the applicable claim determination period shall be reduced to the extent necessary so that the sum of reduced benefits and all the benefits payable for allowable expenses under all other health Plans, except as provided elsewhere in this Section, shall not exceed the total of allowable expenses. Benefits payable under another health Plan include the benefits that would have been payable had claim been duly made therefore.

6.7.3. Except where in conflict with federal or state law, or regulations promulgated thereunder, the benefits of any other health Plan which covers the Enrollee shall be determined before the benefits of BH.

6.7.4. When this provision operates to reduce the total amount of benefits otherwise payable as to a person covered under this Plan during any claim determination period, each benefit that would be payable in the absence of this provision shall be reduced proportionately, and such reduced amount shall be charged against any applicable benefit limit of this Plan.

6.8. Coordination of Benefits Reporting

6.8.1. CONTRACTOR shall report to HCA on its coordination of benefits activities and its data collection methods by the dates specified in Exhibit 11 ~~twice yearly. For claims paid from January 1, 2010, through June 30, 2010, the report shall be submitted to HCA by July 31, 2010. For claims paid from July 1, 2010 through December 31, 2010, the report shall be submitted to HCA by February 1, 2011~~.

7. DATA REPORTING

CONTRACTOR shall submit the following data to HCA:

7.1. Health Plan Employer Data and Information Set (HEDIS®)

CONTRACTOR is required to submit audited HEDIS® information on the BH non-Medicaid population. CONTRACTOR and HCA agree that the HEDIS® audit will be performed by a third party vendor under contract with the Department of Social and Health Services.

All BH CONTRACTORS must comply with the HEDIS® requirements set forth in the BH Plus and Maternity Benefits Program contract.

7.2. Consumer Assessment of Health Plans (CAHPS™) Survey

Contractor shall submit a copy of its final commercial CAHPS™ report from Contractor's vendor no later than August 30, ~~2009~~2011. (See Exhibit ~~5~~4 for instructions.)

7.3. Experience Data Reports

7.3.1. CONTRACTOR shall provide health experience data (utilization and costs) for services rendered during the term of this Agreement. CONTRACTOR shall provide this data for the current year, as well as all outstanding data from any previous Agreement year, whether or not this Agreement is renewed for any subsequent term. Experience data shall be submitted on a yearly basis consistent with the instructions in Exhibit ~~8~~7.

7.3.2. Should CONTRACTOR merge, be acquired by, or otherwise become affiliated with another health plan, whether or not that health plan is under contract with HCA at the time of the merger, acquisition, or other affiliation, CONTRACTOR shall provide the required health experience data for the entire calendar year as well as data from any previous calendar year for which data is outstanding as of the date of the merger, acquisition, or other affiliation. HCA reserves the right to modify or clarify the data request at that time.

7.3.3. CONTRACTOR shall reimburse HCA for the reasonable cost of obtaining CONTRACTOR'S experience data in the event CONTRACTOR does not provide data in accordance with the terms of this Agreement.

- CONTRACTOR shall also provide the same health experience data (utilization and costs), consistent with instructions as described in Exhibit ~~8~~7, for enrolled Health Coverage Tax Credit (HCTC) enrollees.

The data set for HCTC enrollees is to be collected and submitted separate and distinct from Basic Health enrollment data.

7.4 Data Reporting – Paid Claims Data

7.4.1. CONTRACTOR shall submit Basic Health and Health Coverage Tax Credit paid claims electronically as per the following requirements:

Encounter and Eligibility Data Submission Obligations: The CONTRACTOR will provide HCA with detailed encounter and eligibility for the Basic Health and HCTC populations on a monthly basis with the data elements listed in Exhibit ~~10~~9. The data will include:

i) The most granular service lines for each claim or encounter should be provided. Data should not be rolled up into aggregate stays or visits.

~~i)~~ii) Data will be submitted monthly, not more than 30 calendar days after the end of the next month. ~~(i.e. for enrollment in and claims paid in January 1, 2010 to January 31, 2010, data will be received by February 28, 2010).~~

~~i)~~iii) Data ~~will~~ must be submitted ~~in a file format agreed upon by the HCA and the CONTRACTOR, including but not limited to DVD, USB Drive, FTP site, or other electronic media that is mutually agreeable~~as a delimited text file and transferred by File Transfer Protocol (FTP) site or as directed by HCA..

~~i)~~iv) Data~~, to be transferred, will be encrypted in a mutually agreed upon method~~ must be encrypted.

~~i)~~v) The CONTRACTOR will provide all identifiers necessary to link providers and members to HCA identifiers.

~~i) The data files will be comma separated or tab delimited.~~

~~ii)~~vi) The CONTRACTOR will supply control totals with the files that include the total number of records, the total number of enrollees for each month, and the total amount billed for each month. These totals should balance to CONTRACTOR financial reports.

7. 5. Denials, Appeals, Grievances (DAG), and Independent Reviews

CONTRACTOR shall maintain a record of all grievances, denials, appeals, and decisions from independent review organizations (IRO) of any adverse decisions by ~~the health plan~~CONTRACTOR. CONTRACTOR shall provide a

report of complete denials, appeals, grievances, and IRO decisions to HCA four times a year as outlined in Exhibit 10. The fourth quarter of 2009 shall be due to the HCA on February 1, 2010. The first quarter of 2010 shall be due to the HCA on May 1, 2010. The second quarter of 2010 shall be due to the HCA on September 1, 2010. The third quarter of 2010 shall be reported to the HCA on November 1, 2010. The fourth quarter of 2010 shall be reported to HCA on February 1, 2011. CONTRACTOR is responsible for maintenance of records for and reporting of any grievances, denials, appeals, and IRO decisions handled by delegated entities. Delegated denials, appeals, grievances, and IRO decisions are to be integrated into CONTRACTOR'S report. The report shall contain all of the data elements formatted as specified in the Grievance System Reporting Requirements, Exhibit 11, or with HCA's prior written approval, may submit a copy of its Denials, Appeals, Grievances, and IRO report submitted to the Department of Social and Health Services for the appropriate time period as outlined in Exhibit 11. HCA reserves the right to audit any reported complaint, grievance, or appeal upon providing CONTRACTOR with 14 days' calendar notice.

7. 6. Rate Adjustment Data Report

7.6.1. To allow for analysis of the impacts of adverse selection, CONTRACTOR shall provide HCA with and enrollment data "crosswalk" file for the months of December 2009 and February 2010. For the purposes of this report, the "crosswalk" file will match CONTRACTOR'S Enrollee member identification numbers with HCA's identification numbers for all Enrollees for the month reported.

7.6.2. CONTRACTOR shall submit its December 2009 and February 2010 enrollment data crosswalk file to HCA or its actuaries by April 1, 2010. If CONTRACTOR'S enrollment data crosswalk file is received after the due date, CONTRACTOR'S data will not be considered and CONTRACTOR shall not be eligible for a rate adjustment, should HCA's analysis indicate the minimum threshold has been met.

7.6.3. HCA or its actuaries will compare prior claims experience of the active Enrollees for the enrollment months of December 2009 and February 2010. If, based on this analysis, HCA or its actuaries determine the data indicate more than a two-percent increase in average risk score for all health plans contracting with Basic Health combined; HCA will adjust the rates prospectively for the remainder of the contract year proportional to the degree of adverse selection realized. Only health plans contracting with Basic Health that submit crosswalk files by the due date will be eligible for a rate adjustment.

7.6.4. Cost decreases, no matter the degree, shall not trigger a rate adjustment. No rate adjustment will be made if none of the health plans contracting with Basic Health submits data per this Section 7.6. or if the minimum two-percent threshold is not met under Section 7.6.3.

7.6.5. For all plans submitting crosswalk data as prescribed in this Section 7.6. any adjustment will be uniform across all submitting health plans. Differences between health plans will not be reflected in any rate adjustment. Should rates be modified as a result of this analysis, any adjustments will be applied prospectively from the date of implementation. Payments made from January 2010 up to the point where rates are increased will not be modified.

7.6.7 No portion of any increase to rates resulting from this process will be passed along to Enrollees.

8. QUALITY OF CARE

8.1. Quality Improvement Program

8.1.1. CONTRACTOR shall maintain a quality improvement program ~~that meets or exceeds the requirements of the HCA's Quality Improvement Standards, a subset of~~comparable to the National Committee for Quality Assurance (NCQA) Standards. ~~(Exhibit 4). If NCQA updates the standards for a July 1, 2010 effective date, the~~ HCA will permit any CONTRACTOR seeking accreditation to administer the updated standards, to the extent they do not conflict with federal or state regulations. HCA will not require a mid-year contract amendment requiring CONTRACTOR to comply with mid-year updated NCQA standards. If HCA determines that a standard adopted by NCQA mid-year should be included in the future, that new standard may be added in a subsequent contract.

8.1.2. CONTRACTOR shall use data provided by HCA and its own data ~~(including external quality review findings, agency audits, contract monitoring activities, and Enrollee complaint and satisfaction survey findings)~~, to identify and correct quality problems ~~and~~ to improve care and service to Enrollees.

8.1.3. If CONTRACTOR has had an accreditation review or visit by NCQA or another accrediting body, CONTRACTOR shall provide the complete report from that organization to HCA. The state representative is allowed to share information with HCA, Department of Health (DOH), and DSHS as needed, to reduce duplicated work for both CONTRACTOR and the State.

8.1.4. CONTRACTOR shall encourage its participating hospitals to self-report on the Leapfrog web site.

8.2. Clinical Outcomes Assessment Program (COAP)

CONTRACTOR shall ~~require~~ encourage Participating Providers of selected cardiac services (CPTs: 33400 -33401, 33403, 33405-33406, 33410-33411, 33413, 33425-33427, 33430, 33460, 33464-33465, 33472, 33474, 33475, 33510-33536, 92980-92984, and 92974) to provide demographic and clinical registry information to the ongoing Clinical Outcomes Assessment Program (COAP), a Certified Quality Improvement Program protected at RCW 43.60.510.

Additionally, when the Foundation establishes its abdominal surgical procedures (SCOAP) program, carriers are encouraged to participate. The selected abdominal surgical CPT codes are: Appendectomy 44950, 44960, 44970; Bariatric Surgery 43644, 43645, 43842-43848, Colon or rectal resection 44140-44147, 44150-44156, 44160, 44204-44208, 44210-44212, 44116, 45123, 45110, 45111, 45112, 45113, 45114, 45116, 45119-45121, 45123, 45126, 45130, 45135, 45136.

~~1.1.~~8.3. Patient Safety

CONTRACTOR shall require participating hospitals, ambulatory care surgery centers, and office-based surgery sites to endorse and adopt procedures for verifying the correct patient, the correct procedure, and the correct surgical site that meets or exceeds those set forth in the Universal Protocol ™ developed by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

8.4 Claims Payment

CONTRACTOR shall comply with the claims payment provisions set forth in WAC 284-43-321, and WAC 284-43-200(7), as amended.

9. DATA RECORDS

9.1. Confidential Personal Information

9.1.1. CONTRACTOR will ~~shall undertake all reasonable efforts to~~ protect and preserve the confidentiality of HCA's data or information which is defined as confidential under state or federal law or regulation or data that HCA has identified as confidential.

9.1.2. HCA and CONTRACTOR shall comply with all applicable federal and state laws and regulations concerning collection, use, and disclosure of Personal Information set forth in Governor Locke's Executive Order 00-03 and Protected Health Information (PHI), defined at 45 CFR Sec. 160.103, as may be amended from time to time. Personal Information or PHI collected, used, or acquired in connection with this Agreement shall be used solely for the purposes of this Agreement. CONTRACTOR shall not release, divulge, publish, transfer, sell, or otherwise make known to unauthorized third parties Personal Information or PHI without the advance express written consent of the individual who is the subject matter of the Personal Information or PHI or as otherwise required in this Agreement or as permitted or required by state or federal law or regulation. CONTRACTOR shall implement appropriate physical, electronic, and managerial safeguards to prevent unauthorized access to Personal Information and PHI. CONTRACTOR shall require the same standards or confidentiality of all its Subcontractors.

9.1.3. The HCA reserves the right to monitor, audit, or investigate the use of Personal Information and PHI of Enrollees collected, used, or acquired by CONTRACTOR during the term of this Agreement. All HCA representatives conducting onsite audits of CONTRACTOR, agree to keep confidential any patient-identifiable information which may be reviewed during the course of any site visit or audit.

9.1.4. Any material breach of this confidentiality provision may result in termination of this Agreement. CONTRACTOR shall indemnify and hold HCA harmless from any damages related to CONTRACTOR'S or Subcontractor's unauthorized use or release of Personal Information or PHI of Enrollees. In the event of termination of this Agreement, HCA and CONTRACTOR agree that it may not be feasible for CONTRACTOR to return or destroy all Personal Information or PHI concerning HCA Enrollees. Thus, if CONTRACTOR is not able to return or destroy all Personal Information or PHI of Enrollees,

CONTRACTOR agrees to continue to apply privacy protections contained in this Section, or as are then in effect, to all Personal Information or PHI retained by CONTRACTOR after termination and for as long as such Personal Information or PHI is in its possession. If CONTRACTOR is able to return or destroy Personal Information or PHI of Enrollees or if CONTRACTOR ceases to do business with HCA, HCA will provide advice on how to transfer information to HCA or to destroy it.

9.2. Health Insurance Portability and Accountability Act of 1996 (HIPAA)

CONTRACTOR and its Subcontractors shall comply with the applicable provisions of the HIPAA Privacy Rule and shall fully cooperate with HCA efforts to implement all applicable HIPAA requirements.

9.2.1 American Recovery and Reinvestment Act.

CONTRACTOR will comply with each provision of the American Recovery and Reinvestment Act of 2009 that extends a Privacy or Security Rule requirement to business associates of covered entities.

9.2.2 Notice of Breach.

If CONTRACTOR or any of its subcontractors allegedly makes or causes, or fails to prevent, a use or disclosure, and notification of that use or disclosure must (in judgment of the HCA) be made under subsection 9.2.1, or under RCW 42.56.590 or 19.255.010 or other applicable law, then:

a) The HCA may choose to make the notifications or direct CONTRACTOR to make them, and

b) CONTRACTOR will pay the costs of the notification.

9.3. Proprietary Data or Trade Secrets

9.3.1. Except as required by law, regulation, or court order, data identified by CONTRACTOR as proprietary trade secret information shall be kept strictly confidential, unless CONTRACTOR provides prior written consent of disclosure to specific parties. Any release or disclosure of data shall include CONTRACTOR'S interpretation.

9.3.2. CONTRACTOR shall identify data which it asserts is proprietary or is trade secret information as permitted by RCW 41.05.026. HCA will notify CONTRACTOR upon receipt of any request under the Public Disclosure Law (chapter 42.56 RCW) or otherwise for data or Claims Data identified by CONTRACTOR as proprietary trade secret information and will not release any such information until 5 business days after it has notified CONTRACTOR of the receipt of such request.

9.3.3. If CONTRACTOR files legal proceedings within the aforementioned 5 calendar day period in order to prevent disclosure of the data, HCA agrees not to disclose the information unless it is ordered to do so by a court, CONTRACTOR dismisses its lawsuit, or CONTRACTOR agrees that the data may be released.

9.3.4. Nothing in this Section shall prevent HCA from filing its own lawsuit or joining any lawsuit filed by CONTRACTOR to prevent disclosure of the data, or to obtain a declaration as to the disclosure of the data, provided that HCA will immediately notify CONTRACTOR of the filing of any such lawsuit.

9.4. Data Ownership

9.4.1. All original material and data, either written or readable by machine, prepared for or with HCA solely for the purposes of this Agreement, ~~except for~~including Claims Data, shall belong to and be the property of ~~CONTRACTOR~~HCA.

9.4.2. ~~All Claims Data is the property of HCA.~~ For the purpose of this Section, "Claims Data" means event level cost and utilization data, including, but not limited to, hospital, facility, professional, dental, and prescription drug services. "Event Level Data" includes, but is not limited to, the cost of Covered Services provided to the Enrollee in accordance with the terms of this Agreement, including, but not limited to, vendor discounts, rebates, capitation payments, or other similar payments made or revenues received for the purpose of administering the health care services under this Agreement. HCA will withhold from public inspection all such data as "cost and utilization data" as provided for in RCW 41.05.026.

9.4.3. ~~CONTRACTOR shall retain custody, possession, and control of all data and will provide it to HCA upon reasonable request in a mutually acceptable form.~~ CONTRACTOR in its sole discretion may attach its interpretation to any data provided to HCA, and any such interpretation shall become a permanent part of such data.

10. PERFORMANCE EXPECTATIONS

10.1. General Expectations

10.1.1. Throughout the period of this Agreement and any subsequent renewals thereof, CONTRACTOR shall maintain a Certificate of Registration as either a Health Maintenance Organization or a Health Care Service Contractor from the Insurance Commissioner. CONTRACTOR shall be in good standing with the Insurance Commissioner and comply with the applicable solvency provisions of Title 48 RCW, as amended and regulations promulgated there under.

10.1.2. CONTRACTOR shall provide access to consistently high-quality, cost-effective care which is designed to improve the health of Enrollees, through efficient, stable networks or delivery systems. Throughout the period of this Agreement, HCA will review and assist CONTRACTOR, where appropriate, to develop or refine its risk management plan to address the performance expectations. CONTRACTOR'S ability to address the performance expectations of this Agreement will be considered when evaluating any renewal offer of this Agreement.

10.2. Demonstrated Superior Quality in Health Care Delivery

CONTRACTOR shall provide evidence that it has and uses the following:
10.2.1. Programs to reach out to Enrollees to ensure appropriate detection of disease, illness, or injury and preventive care services are available and effectively delivered.

10.2.2. A plan that considers community health issues, including, but not limited to, collaboration with other local health plans or health departments.

10.2.3. A plan which provides for all aspects of Enrollee health, including minimizing Enrollee disability and absenteeism. CONTRACTOR shall be able to demonstrate how its plan incorporates disease management standards which reinforce quality of care.

10.2.4. CONTRACTOR shall be able to describe its use of up-to-date standards for patient safety and Provider feedback, including a description for evaluating safety concerns.

10.2.5. A plan to improve its quality, care delivery and satisfaction scores, and other standard measures; for example, HEDIS® and CAHPS™.

10.2.6. A plan (including timelines) to meet or exceed the transaction, security and privacy requirements of state and federal law (including chapter 70.02 RCW, the Washington State Patient Bill of Rights, HIPAA, and to protect the Personal Information and PHI of Enrollees.

10.2.7. CONTRACTOR'S formulary must reflect an evidence-based formulary that includes all therapeutic classes of drugs and meets or exceeds the recommendations set forth by the Academy of Managed Care Pharmacists. Additionally, CONTRACTOR is encouraged to expand its Pharmacy & Therapeutics Committee to include at least one voting professional provider who is not employed by CONTRACTOR.

10.3. Access to Health Care Services

CONTRACTOR shall ensure that an adequate network of Providers that deliver high quality health care services is available to Enrollees. HCA will apply the ~~Quality Improvement Standards (Exhibit 4) and the~~ Network Accessibility Guidelines (Exhibit ~~7~~6) when evaluating a CONTRACTOR'S network adequacy. Upon request, CONTRACTOR shall demonstrate that it ensures the following, for the benefit of HCA Enrollees:

10.3.1. A comprehensive, organized system of care that is accountable for delivery, development, and performance throughout the period of the Agreement.

10.3.2. Accessible, high quality PCPs, specialists, hospitals, and pharmacies. CONTRACTOR shall be able to demonstrate how its network is of sufficient size and distribution to meet Enrollee needs, and meets or exceeds the ~~network~~ Network A~~a~~ccessibility G~~g~~uidelines (Exhibit 6)~~of HCA~~.

10.3.3. Long-term relationships with Providers. CONTRACTOR shall be able to demonstrate that its Provider relationships are designed to ensure that continuity and coordinated care are available to Enrollees.

10.3.4. Adequate and timely access to medically appropriate Providers outside the contracted network, without additional expense, if there is an insufficient number of Participating Providers.

10.4. Accountability for Delivery of Affordable Health Care

In its demonstration of fiscal accountability to HCA, Enrollees, and Providers, CONTRACTOR shall provide for and ensure that CONTRACTOR has and uses the following:

10.4.1. Financial contracts and agreements with Providers which focus on efficiency and effectiveness of health care.

10.4.2. A plan to improve administrative systems that promote CONTRACTOR'S performance and efficiencies, including information management systems to support HCA's expectations and objectives and, in particular, the ability of CONTRACTOR to monitor and promote continuous quality improvements. Upon request, CONTRACTOR shall demonstrate how such programs reinforce quality of care and do not impede access to or the delivery of care.

10.4.3. Financial arrangements with Providers that are designed to ensure Enrollees receive appropriate and cost-effective care.

10.4.4. A risk management plan that is designed to anticipate and reduce threats to continued Enrollee access to care.

10.4.5. A system to incorporate disease management, use of clinical guidelines, and evidence-based medicine.

10.4.6. Policies and procedures to prevent and detect fraud and abuse activities related to the BH program. These may include, but not be limited to: claims prior authorization, utilization management and quality review, Enrollee complaint and grievance resolution, Provider credentialing and contracting, Provider and staff education to prevent fraud and abuse, and corrective action plans to remedy situations where fraud and abuse have been detected.

10.5. Performance ~~Measures~~Standards

~~1.1.1.~~10.5.1. CONTRACTOR agrees to comply with the performance ~~measures~~ standards as outlined in Exhibit 3. CONTRACTOR agrees to maintain adequate records, satisfactory to HCA, documenting compliance with these ~~measures~~standards.

10.5.2. CONTRACTOR shall self-report compliance with the performance ~~measures~~ standards and submit them as described in Exhibit ~~3 on July 31 for the contract period January 1 through June 30 and on January 31 of the following year for the period July 1 through December 31 of the contract period~~. If HCA determines that it is not feasible for CONTRACTOR to report compliance with a ~~measure~~ standard on a BH-specific basis, then CONTRACTOR may report compliance with that ~~measure~~ standard for its total book of business. Performance standards relating to CAHPS™~~CAHPS~~ survey results will be obtained through the survey results and does not need to be included in the above-mentioned report.

11. APPEALS AND COMPLAINTS

~~1.1.~~11.1. Enrollee Complaints and Appeals Procedure

CONTRACTOR shall establish and maintain a procedure for the timely resolution of complaints and appeals from Enrollees that meets the requirements in ~~the Quality Improvement Standards (Exhibit 4),~~Exhibit 10 or any other applicable provision of this Agreement, or as required by federal or state law or regulation.

~~1.1.~~11.2. **Grievance Timelines**

CONTRACTOR will provide written notice of its resolution of a grievance (as defined in RCW 48.43.005 (14)) to an Enrollee within 30 calendar days of the receipt of the grievance, unless CONTRACTOR notifies the Enrollee that an extension is necessary to complete the grievance review process and the Enrollee gives informed, written consent to an extension.

~~10.0.~~11.3. **Dispute and Dispute Resolution Hearings**

11.3.1. Except as otherwise provided in this Agreement, when a bona fide dispute arises between HCA and CONTRACTOR and it cannot be resolved, CONTRACTOR may request a dispute resolution hearing with the Administrator. The request for a dispute resolution hearing must be in writing and shall clearly state all of the following:

~~(0)~~(1) The disputed issue(s),

~~(0)~~(2) An explanation of the positions of the parties, and

~~(0)~~(3) Any additional facts necessary to explain completely and accurately the nature of the dispute.

11.3.2. Requests for a dispute resolution hearing shall be mailed to the Administrator, Washington State Health Care Authority (HCA), P.O. Box 42700, Olympia, WA 98504-2700 within 15 calendar days after CONTRACTOR receives notice of the disputed issue(s). The Administrator will determine a time that is mutually agreeable to the parties during which they may present their views on the disputed issue(s). The format and time allowed for the presentations are solely within the Administrator's reasonable discretion, but it is understood that such presentations will be informal in nature. The Administrator will provide written notice of the time, format, and location of the presentations. At the conclusion of the presentations, the Administrator will consider all of the evidence available ~~to him~~ and shall render a written recommendation as soon as practicable, but in no event more than 30 calendar days after the conclusion of the presentations. The Administrator may designate an employee of HCA or an Administrative Law Judge to hear and determine the matter.

11.3.3. The parties hereby agree that this dispute process shall precede any judicial or quasi-judicial proceeding.

12. GENERAL PROVISIONS

12.1. Accessibility of Covered Services

CONTRACTOR shall ensure Enrollees have access to Covered Services defined in the COC (Exhibit 2) by the medically appropriate Provider.

12.1.1. Network Adequacy. CONTRACTOR shall maintain the support services and a Provider network sufficient to serve Enrollees, consistent with the requirements of this Agreement. CONTRACTOR will provide the Covered Services required by this Agreement through non-Participating ,with no additional expense, Providers if its network of Participating Providers is insufficient to meet the medical needs of Enrollees in a manner consistent with this Agreement. CONTRACTOR shall make services accessible consistent

with the provisions of this Agreement, including, but not limited to, the ~~Quality Improvement Standards (Exhibit 4) and the~~ Network Accessibility Guidelines (Exhibit ~~7~~6). CONTRACTOR shall make Covered Services as accessible to Enrollees under this Agreement as under its other state, federal, or private contracts. CONTRACTOR shall submit to the HCA quarterly geo access reports demonstrating CONTRACTOR's adherence to the standards set forth in Exhibit 6.

12.1.2. 24/7 Availability of Services. CONTRACTOR shall have the following services available to Enrollees on a 24 hour-a-day, 7 days a week basis. These services may be provided directly by the CONTRACTOR or may be delegated to Subcontractors, provided that all Subcontractors perform subject to the applicable terms and conditions of this Agreement:

12.1.2.1. Medical advice for Enrollees from licensed health care professionals concerning the emergent, urgent, or routine nature of a medical condition.

12.1.2.2. Authorization of emergency services, out-of-area urgent care, or authorizing care at other facilities when the use of participating facilities is not practical.

12.1.3. Office Appointment Standards. CONTRACTOR shall comply with appointment standards that are no longer than the following:

12.1.3.1. Non-symptomatic (e.g., preventive care) office visits shall be available from the Enrollee's PCP or an alternative provider within 30 calendar days. A non-symptomatic office visit may include, but is not limited to, well/preventive care such as physical examinations, annual gynecological examinations, or children and adult immunizations.

12.1.3.2. Non-urgent, symptomatic (e.g., routine care) office visits shall be available from the Enrollee's PCP or an alternative practitioner within 10 business days. A non-urgent, symptomatic office visit is associated with the presentation of medical signs not requiring immediate attention.

12.1.3.3. Urgent, symptomatic office visits shall be available within 48 hours. An urgent, symptomatic visit is associated with the presentation of medical signs that require immediate attention, but are not life threatening.

12.1.3.4. Emergency medical care shall be available 24 hours per day, 7 days per week.

12.1.4. Access to Specialty Care. CONTRACTOR shall provide for availability of necessary covered specialty care for Enrollees in a Service Area. If an Enrollee needs specialty care from a specialist who is not available within CONTRACTOR'S Participating Provider network, CONTRACTOR shall provide the necessary services with a qualified specialist outside CONTRACTOR'S Participating Provider network without additional expense (except applicable coinsurance or copayment amounts) to the Enrollee and to HCA.

12.1.5. Equal Access for Enrollees with Communications Barriers. CONTRACTOR shall assure equal access of Covered Services, as described in the COC (Exhibit 2), for all Enrollees when oral or written language creates a barrier to such access.

12.1.6. Americans with Disabilities Act. CONTRACTOR shall make reasonable accommodation for Enrollees with disabilities, in accord with the Americans with Disabilities Act, for all Covered Services and shall assure physical and communication barriers shall not inhibit Enrollees with disabilities from obtaining Covered Services.

12.2. Administrative Simplification

12.3.1. To maximize understanding, communication, and administrative economy among all BH CONTRACTORS, their Subcontractors, governmental entities, and Enrollees, CONTRACTOR shall use and follow the most recent updated versions of:

- Current Procedural Terminology (CPT)
- International Classification of Diseases (ICD-9 CM)
- Healthcare Common Procedure Coding System (HCPCS)
- CMS Relative Value Units (RVUs)
- CMS billing instructions and rules, including CMS1500 & UB-92 instructions

12.3.2. In lieu of the most recent versions, CONTRACTOR may request an exception. HCA's consent thereto will not be unreasonably withheld.

12.3.3. CONTRACTOR may set its own conversion factor(s), including special code-specific or group-specific conversion factors, as it deems appropriate.

12.3. Assignment

Responsibilities and rights under this Agreement may not be assigned by either CONTRACTOR or HCA without the prior written consent of the other party, which consent will not be unreasonably withheld.

12.4. Audits and Performance Reviews

~~11.3.0.~~12.4.1. HCA may undertake periodic audits or performance reviews at its expense regarding any aspect of the provision of Covered Services or CONTRACTOR'S administration of this Agreement. Such audits or reviews will be designed not to interfere with the delivery of health care services by Participating Providers of CONTRACTOR. Audits or reviews may be undertaken directly by HCA, by third parties engaged by HCA, or the State of Washington Auditor's Office. With reasonable advance written notice, CONTRACTOR and its Subcontractors shall provide access to its facilities and the financial and medical records pertinent to this Agreement to monitor and evaluate performance under this Agreement, including, but not limited to, the quality, cost, use, and timeliness of services, and assessment of the CONTRACTOR'S capacity to bear the ~~potential financial losses~~financial obligation of BH claims costs and reserves.

12.4.2. CONTRACTOR agrees to provide HCA the results of final financial reports, market conduct, or special examinations performed by the Office of the Insurance Commissioner (OIC) and/or any final audit report produced by the U. S. Department of Health and Human Services.

12.4.3. CONTRACTOR shall submit a business or corrective action plan, including timelines for remediation, in response to any final audit or performance review recommendations identified by HCA or its agent. Such action plan ~~is due to the HCA within 60 calendar days after the date on the final report~~must be included in the quarterly report as outlined in Exhibit 3.

12.5. Clerical Error

No clerical error on the part of HCA or CONTRACTOR, which is discovered within 12 months of its occurrence, shall operate to defeat any of the obligations, rights, privileges, or benefits of any Enrollee.

12.6. Compliance With All Applicable Laws and Regulations

12.6.1. In the provision of services under this Agreement, the HCA, CONTRACTOR, and its Subcontractors shall comply with all applicable federal and state statutes and regulations, and all amendments thereto, that are in effect when the Agreement is signed or that come into effect during the term of the Agreement or any renewals thereof. The provisions of this Agreement which are in conflict with applicable state or federal laws or regulations are hereby amended to conform to the minimum requirements of such laws or regulations.

12.6.2. CONTRACTOR and HCA shall comply with all the applicable provisions of the HIPAA

12.6.3. CONTRACTOR shall comply with all the applicable provisions of chapter 70.02 RCW and the Washington State Patient Bill of Rights, including, but not limited to, the administrative and financial responsibility for independent reviews.

12.6.4 The HCA and CONTRACTOR agree to engage in good faith negotiation to address any changes created by National Healthcare Reform (NHR) and to negotiate amendments to this Agreement as necessary to comply with NHR. If any NHR change or amendment to this Agreement negatively impacts CONTRACTOR, then the parties will in good faith renegotiate the monthly fees set forth in Exhibit 1 of this Agreement.

12.7. Covenant Against Contingent Fees

CONTRACTOR certifies that no person or selling agent has been employed or retained to solicit or secure this Agreement for a commission, percentage, brokerage or contingent fee, excepting bona fide employees or bona fide established agents maintained by CONTRACTOR for the purpose of securing business. HCA shall have the right, in the event of breach of this clause by CONTRACTOR, to terminate this Agreement or, in its discretion, to deduct from amounts due CONTRACTOR under the Agreement or recover by other means the full amount of any such commission, percentage, brokerage or contingent fee.

12.8. Customer Service

~~11.7.0.~~12.8.1. CONTRACTOR shall provide adequate staff to provide customer service representation at a minimum from 8 a.m. to 5 p.m., Pacific Standard Time or Daylight Savings Time (depending on the season), Monday through Friday, year round and shall provide customer service on all dates that are recognized as work days for state employees. HCA will authorize exceptions to this requirement if CONTRACTOR provides HCA with written assurance that its Participating Providers will accept enrollment information from the BH Provider Line or HCA's system-generated notice to the Enrollee that acknowledges his or her enrollment with CONTRACTOR. "Work days for state employees" shall include days designated as "temporary lay-off" or "furlough" days under state law.

~~11.7.0.~~12.8.2. Toll free numbers shall be provided at the expense of CONTRACTOR for out-of-state and in-state lines.

~~11.7.0.~~12.8.3. CONTRACTOR shall provide a list of known dates that are not considered business days for CONTRACTOR, but are considered work days for state employees no later than ~~March~~ February 1, 2010. Throughout the period of this Agreement, CONTRACTOR shall give HCA not less than 30 calendar days' prior notice of any additional dates that subsequently are identified where customer service representation will be unavailable to BH Enrollees. "Work days for state employees" shall include days designated as "temporary lay-off" or "furlough" days under state law.

12.9. Defense of Legal Actions

Each party to this Agreement shall advise the other as to matters that come to its attention with respect to potential substantial legal actions involving allegations that may give rise to a claim for indemnification from the other. Each party shall fully cooperate with the other in the defense of any action arising out of matters related to this Agreement by providing without additional fee all reasonably available information relating to such actions and by providing necessary testimony.

12.10. Financial Solvency

12.10.1. CONTRACTOR shall deliver to HCA copies of any financial reports prepared at the request of the Office of the Insurance Commissioner (OIC). CONTRACTOR'S routine quarterly and annual statements submitted to the OIC are exempt from this requirement. CONTRACTOR shall also deliver copies of related documents and correspondence (including, but not limited to, Risk-Based Capital [RBC] calculations and Management's Discussion and Analysis), at the same time CONTRACTOR submits them to the OIC.

12.10.2. CONTRACTOR shall notify HCA within 10 business days after the end of any month in which CONTRACTOR'S net worth (capital and/or surplus) reaches a level representing two or fewer months of expected claims and other operating expenses, or other change which may jeopardize its ability to perform under this Agreement or which may otherwise materially affect the relationship of the parties under this Agreement.

12.10.3. CONTRACTOR shall notify HCA within 24 hours after any action by the Insurance Commissioner which may affect the relationship of the parties under this Agreement.

12.10.4. CONTRACTOR shall notify HCA if the OIC requires enhanced reporting requirements within 14 calendar days after CONTRACTOR'S notification by the OIC. CONTRACTOR agrees that HCA may, at any time, access any financial reports submitted to the Insurance Commissioner in accordance with any enhanced reporting requirements and consult with OIC staff concerning information contained therein.

12.10.5. If CONTRACTOR, any Subcontractor, or any Participating Provider becomes insolvent during the term of this Agreement:

12.10.5.1. The state of Washington, HCA, and its Enrollees shall not be liable in any manner for the debts and obligations of the CONTRACTOR.

12.10.5.2. Under no circumstances shall CONTRACTOR, or any Provider who delivers Covered Services under the terms of this Agreement, charge Enrollees more than the Enrollee cost share set forth in the COC (Exhibit 2).

12.10.5.3. CONTRACTOR shall provide for the continuity of care for Enrollees in accordance with RCW 48.44.055.

12.11. Force Majeure

If CONTRACTOR is prevented from performing any of its obligations hereunder, in whole or in part, as a result of major epidemic, act of God, act of war (declared or undeclared), civil disturbance, court order, labor dispute, or any other cause beyond its control, CONTRACTOR shall make a good faith effort to perform such obligations through its then-existing Participating Providers and personnel. Upon the occurrence of any such event, if CONTRACTOR is unable to fulfill its obligations either directly or through Participating Providers, CONTRACTOR shall make a good faith effort to arrange for the provision of alternate and comparable performance.

12.12. Governing Law and Venue

This Agreement shall be governed by the laws of the state of Washington. In the event of a lawsuit involving this Agreement, venue shall be proper only in the Superior Court of Thurston County.

12.13. HCA and Enrollee Protection

12.13.1. Any written referral by a Participating Provider or contracted Referral Provider is considered a CONTRACTOR-authorized referral unless the Enrollee (or Enrollee's legal representative) is given a copy of a statement acknowledging that the referral services will not or may not be covered by CONTRACTOR, or that the referral must have prior authorization by CONTRACTOR to ensure that the services are a covered benefit. CONTRACTOR may not deny charges for referral services unless

CONTRACTOR, or a Participating Provider or contracted Referral Provider on behalf of CONTRACTOR, has first provided the above-referenced statement to the Enrollee or Enrollee's legal representative.

12.13.2. Under no circumstances shall CONTRACTOR, or any Provider used to deliver Covered Services under the terms of this Agreement, charge an Enrollee more than the Enrollee cost share set forth in the COC (Exhibit 2) including, but not limited to, emergent care or Covered Services administered by a Provider referred by CONTRACTOR or referred by CONTRACTOR'S Participating Providers.

12.14. Indemnification

HCA and CONTRACTOR shall each be responsible for its own acts and omissions, and the acts and omissions of its agents and employees. Each party to this Agreement shall defend, protect and hold harmless the other party, or any of the other party's agents, from and against any loss and all claims, settlements, judgments, costs, penalties, and expenses (including attorney fees) arising from any willful misconduct, or dishonest, fraudulent, reckless, unlawful, or negligent act or omission of the first party, or agents of the first party, while performing under the terms of this Agreement except to the extent that such losses result from the willful misconduct, or dishonest, fraudulent, reckless, unlawful or negligent act or omission on the part of the second party. CONTRACTOR shall indemnify and hold harmless HCA from any claims by Participating or non-Participating Providers related to the provision of Covered Services to Enrollees according to the terms of this Agreement. Each party agrees to promptly notify the other party in writing of any claim and provide the other party the opportunity to defend and settle the claim.

12.15. Independent Parties

CONTRACTOR acknowledges and certifies that its directors, officers, partners, employees, and agents are not officers, employees, or agents of HCA or the state of Washington. CONTRACTOR shall not hold itself out as or claim to be an officer, employee, or agent of HCA or the state of Washington by reason of this Agreement. CONTRACTOR shall not claim any rights, privileges, or benefits that would accrue to a civil service employee under chapter 41.06 RCW.

12.16. Industrial Insurance Coverage

CONTRACTOR shall provide or purchase industrial insurance coverage prior to performing work under this Agreement. HCA will not be responsible for payment of industrial insurance premiums or for any other claim or benefit for CONTRACTOR, or any Subcontractor or employee of CONTRACTOR, which might arise under the industrial insurance laws during performance of duties and services under this Agreement.

12.17. Integration and Modification of Agreement

Any amendment to this Agreement shall require the approval of both HCA and CONTRACTOR. Any amendment shall be in writing and shall be signed by a CONTRACTOR'S authorized officer and an authorized representative of HCA. No other understandings, oral or otherwise, regarding the subject matter of this Agreement shall be deemed to exist or to bind any of the parties hereto.

12.18. Intermediate Sanctions

12.18.1. If CONTRACTOR fails to meet a material obligation under the terms of this Agreement, HCA may impose intermediate sanctions by withholding up to 5 percent of payments to the CONTRACTOR rather than terminate this Agreement. CONTRACTOR agrees that any intermediate sanction assessed by HCA shall not be regarded as a waiver of any requirements contained in this Agreement or any provision therein, nor as a waiver by HCA of any other remedy available in law or in equity.

12.18.2. HCA will notify CONTRACTOR in writing of any default and provide a reasonable deadline for curing the default before imposing intermediate sanctions. CONTRACTOR may request a dispute resolution hearing, as described at Section 11.2. of this Agreement (Disputes and Dispute Resolution Hearings). CONTRACTOR agrees that any intermediate sanction assessed under this Section shall be in addition to any other legal or equitable remedies allowed by this Agreement or awarded by a court of law, including injunctive relief.

12.18.3. If the dispute is resolved in favor of CONTRACTOR, HCA shall immediately pay to CONTRACTOR any and all withheld payments. Interest shall not accrue on any amount withheld as an intermediate sanction. If the dispute is resolved in favor of HCA, HCA may withhold said amounts until such breach is cured.

12.19. Licensing, Registration, Certification, and Authorization

CONTRACTOR shall comply with all applicable local, state, and federal licensing, certification, accreditation, and registration standards and requirements necessary for the performance of this Agreement, including, but not limited to, licensing, registration, certification, or authorization as a health maintenance organization, health care service contractor, or disability insurer under Title 48 RCW.

12.20. Marketing and Written Communication Materials

12.20.1. CONTRACTOR shall not engage in any marketing activity related to this Agreement without the prior written approval of HCA.

12.20.2. CONTRACTOR will not use identifying marks of BH, HCA, or the state of Washington on any materials produced or issued by CONTRACTOR without the prior written consent of HCA. This contract term includes, but is not limited to marketing, advertising, or other direct communications to members, terminated members, or potential members.

12.20.3. CONTRACTOR agrees not to represent itself as endorsed, supported by, or affiliated with the state of Washington.

12.20.4. CONTRACTOR agrees to submit all written communications and marketing materials, developed and used by CONTRACTOR to communicate specifically with BH Enrollees at any time during the contract period, to HCA for review and approval. This subsection does not refer to such items as Provider directories and plan-wide newsletters as long as they do not contain information on eligibility, enrollment, benefits, rates, etc., which HCA must review.

12.20.5. CONTRACTOR agrees that it will not advertise or distribute any information to BH Enrollees, terminated BH Enrollees, and candidates for BH enrollment or Providers that contains false or misleading information. Violation of this subsection is subject to the Rights and Remedies defined in Sections 3.1. and 12.18. of this Agreement. CONTRACTOR further agrees that if erroneous or misleading information is sent to an Enrollee or Subcontractors (including contracted Providers) regarding any matter related to this Agreement, HCA may require CONTRACTOR to mail a correction or clarification to correctly inform the recipients of such written materials.

12.20.6. Nothing in this Section shall be construed to prohibit CONTRACTOR from acknowledging that it has entered into this Agreement with HCA.

12.21. Mergers and Acquisitions

If a CONTRACTOR is involved in an acquisition of assets or merger with another HCA CONTRACTOR after the effective date of this Agreement, HCA reserves the right, to the extent permitted by law, to require that each CONTRACTOR maintain its separate business lines for the remainder of the Agreement period.

12.22. Nondiscrimination

During the performance of this Agreement, CONTRACTOR, and any of its Subcontractors performing any of the obligations of CONTRACTOR set forth in this Agreement, shall comply with all federal and state laws, regulations, and Executive Orders regulating discrimination. These include, but are not limited to, the following and any amendments thereto: Titles VI and VII of the Civil Rights Act of 1964, Executive Order 11246 as amended by Executive Order 11375, Sections 503 and 504 of the Rehabilitation Act of 1973, the Age Discrimination in Employment Act of 1967, the Age Discrimination Act of 1975, the 1974 Vietnam Era Veterans Readjustment Assistance Act, the Americans with Disabilities Act of 1990, as amended, including the provisions of Title II as if they were a public entity, the Civil Rights Act of 1991, and the Washington State Law Against Discrimination (chapter 49.60 RCW).

12.23. Noncompliance with Nondiscrimination Laws

In the event of noncompliance with any nondiscrimination law, regulation, or policy by CONTRACTOR, HCA may rescind, cancel, or terminate this Agreement in whole or in part, and CONTRACTOR may be declared ineligible for further contracts or agreements with HCA for a period of up to 2 years. CONTRACTOR shall be given a reasonable time, not to exceed 60 calendar

days, in which to cure this noncompliance. Any dispute may be addressed in accordance with Section 11.2. (Disputes and Dispute Resolution Hearings).

12.24. Notification of Organizational Changes

CONTRACTOR shall provide HCA with 90 calendar days' prior written notice of any change in CONTRACTOR'S ownership or legal status. CONTRACTOR shall provide HCA notice of any changes to CONTRACTOR'S key personnel including, but not limited to, CONTRACTOR'S Chief Executive Officer, HCA government relations contact, the HCA Account Executive, and Medical Director as soon as reasonably possible.

12.25. Subcontracts

12.25.1. Subcontracts, as defined at Section 1.22., may be used by CONTRACTOR for the provision of any service under this Agreement; however, no Subcontract shall act to terminate CONTRACTOR'S legal responsibility to HCA for any work required to be performed under this Agreement. If the terms or conditions of an agreement between CONTRACTOR and its Subcontractors conflict with this Agreement, the terms and conditions of this Agreement shall prevail for purposes of administration of this Agreement.

12.25.2. CONTRACTOR is responsible for ensuring that all terms, conditions, assurances, and certifications set forth in this Agreement are carried forward to any Subcontractors, including, but not limited to, those contract terms set forth in Section 9. (Data Records), Section 12.1. (Accessibility of Covered Services), Section 12.13. (HCA and Enrollee Protection), and Section 12.27. (Records Maintenance and Retention). CONTRACTOR shall be responsible for educating its Subcontractors on the nature and purpose of CONTRACTOR'S relationship with HCA, including Covered Services for Enrollees under this Agreement, coordination of care requirements, and HCA policies as they relate to this Agreement.

12.25.3. If a Subcontractor is at financial risk and CONTRACTOR imposes solvency requirements on the Subcontractor, the terms of the solvency requirement and how frequently and by what means CONTRACTOR will monitor compliance with solvency requirements must be in writing and enforced throughout the term of the Subcontract agreement.

12.25.4. Contracts or Subcontracts with Providers, including those for facilities, must ensure the terms and conditions of this Agreement apply to the Subcontractor. The Subcontract must also contain the following provisions:

12.25.4.1. A quality improvement system tailored to the nature and type of services subcontracted which affords quality control for the health care provided, including, but not limited to, the accessibility of Covered Services in accordance with the terms and conditions set forth in this Agreement, and which provides a free exchange of information with CONTRACTOR to assist CONTRACTOR in complying with Sections 8. and 10. of this Agreement.

12.25.4.2. A 90 calendar day termination notice provision for Participating Providers and a specific "short term" notice of termination when a Provider is excluded from participation due to quality of care concerns.

12.25.4.3. Whether referrals for Enrollees will be restricted to Providers affiliated with a specific network group and, if so, a description of those restrictions.

12.25.4.4. The Subcontractor accepts payment from CONTRACTOR as payment in full and shall not request payment from HCA or any Enrollee for any services performed under the Subcontract.

12.26. Provider Network Changes

12.26.1. CONTRACTOR shall furnish health care services at its health care facilities or through its Participating Providers throughout the term of this Agreement.

12.26.2. CONTRACTOR shall provide HCA not less than 90 calendar days' advance written notice of termination of a Material Provider.

12.26.2.1. In the event CONTRACTOR receives fewer than 90 calendar days' notice of termination from a Material Provider, CONTRACTOR shall provide written notice of the termination to HCA within 5 business days after CONTRACTOR'S receipt of the termination notice from the Provider.

12.26.2.2. If CONTRACTOR gives HCA fewer than 90 calendar days' termination notice to a Material Provider due to the Provider's loss of accreditation or Medicare or Medicaid certification, or because of serious concerns about service delivery or quality of care, CONTRACTOR shall notify HCA within 5 business days after such termination.

12.26.2.3. If HCA receives fewer than 90 calendar days' notice of termination of a Participating Provider determined by HCA to be material to the performance of this Agreement and the access goals of HCA, HCA may, at its sole discretion, require CONTRACTOR to continue providing services through the Material Provider for a period not to exceed 90 calendar days. CONTRACTOR shall cooperate with HCA to ensure continuity of care and that treatment protocols are not materially affected by Provider terminations. CONTRACTOR shall cooperate with HCA to effect the orderly transition of Enrollees to other Participating Providers or programs of health care coverage for which such Enrollees may be eligible.

12.26.3. If CONTRACTOR requires a Participating Provider to accept a revised structure or method of reimbursement (e.g., moving from a fee schedule reimbursement methodology to full-risk capitation payment) during the period of this Agreement as a condition of continued participation with CONTRACTOR and the change is rejected by the Provider, CONTRACTOR shall extend the terms of the existing Subcontract to continue service for BH Enrollees until the end of the calendar year in which the change is proposed.

12.26.4. CONTRACTOR shall notify Enrollees affected by any Provider termination which occurs without cause, 60 calendar days prior to the effective

date. Notices to Enrollees of Provider termination shall have prior approval of HCA. If CONTRACTOR fails to notify affected Enrollees of a Provider termination 60 calendar days prior to the effective date, CONTRACTOR shall allow affected Enrollees to continue to receive services from the terminating Provider, at the Enrollees' option, and administer benefits to the lesser of a period of 60 calendar days from the date CONTRACTOR notifies Enrollees of the termination or the Enrollee's effective date of enrollment with another Provider or another BH CONTRACTOR.

12.26.5. If because of changes in the Participating Provider network, the network becomes so changed that Enrollees are unable to obtain timely services from Participating Providers, or if in the sole judgment of HCA the change in network adversely impacts Enrollees, HCA may transfer the affected Enrollees to another CONTRACTOR.

12.26.6. HCA reserves the right to reduce the December premium to recover any expenses incurred by HCA as a result of the withdrawal of a material Subcontractor from a Service Area. This reimbursable expense shall be in addition to any other provisions of this Agreement.

12.27. Records Maintenance and Retention

12.27.1. CONTRACTOR and its Subcontractors shall maintain financial, medical, and other records relevant to this Agreement. Medical records and supporting management systems shall include all relevant information related to the medical management of each Enrollee. Other records shall be maintained as necessary to clearly reflect all actions taken by CONTRACTOR related to this Agreement.

12.27.2. All records and reports relating to this Agreement, and any subsequent amendments extending the effective date of this Agreement, shall be retained by CONTRACTOR and its Subcontractors for a minimum of six (6) years after final payment is made under this Agreement. When an audit, litigation, or other action involving records is initiated prior to the end of said period, records shall be maintained for a minimum of six (6) years following resolution of such action.

12.28. Post Termination Responsibilities

The following requirements survive termination of this Agreement. CONTRACTOR shall:

12.28.1. Cover Enrollees hospitalized on the date of termination until discharge, consistent with subsections 3.6.4. and 12.10.5.3. of this Agreement.

12.28.2. Submit all data and reports required in Sections 6. and 7. of this Agreement.

12.28.3. Provide access to records, as required in Section 12.4. of this Agreement.

12.28.4. Provide administrative services associated with Covered Services (e.g., claims processing and Enrollee appeals) provided to Enrollees under the terms of this Agreement.

12.29. Required Notices

Any notice required hereunder shall be deemed to be sufficient if mailed to the addresses appearing on the signature page of this Agreement.

12.30. Services Non-Transferable

No person other than the Enrollee is entitled to receive services and benefits furnished under this Agreement. Rights to services and benefits are not transferable.

12.31. Severability

If any provision of this Agreement or any provision of any document, law, or regulation incorporated by reference shall be held invalid, such invalidity shall not affect the other provisions of this Agreement which can be given effect without the invalid provision, and to this end the provisions of this Agreement are declared to be severable.

12.32. Waiver

Waiver of any default shall not be deemed to be a waiver of any subsequent default. Waiver of breach of any provision of this Agreement shall not be deemed to be a waiver of any other or subsequent breach and shall not be construed to be a modification of the terms of this Agreement unless stated to be such in writing, signed by the parties, and attached to the original Agreement.